



Request For Additional MFP Transition Services



MFP Facilitator (OC, TC, PLA, CE): To obtain approval for additional MFP Transition Services, complete the following form. Services listed on this form must be needed by the participant and not initially identified in the ITP/PCD by the team. The MFP participant initials each additional service.

Participant First Name:

Participant Last Name:

Participant Medicaid #:

Participant Date of Birth:

Participant Address:

Participant City:

State: GA

Zip:

Waiver Name:

Participant Phone Number:

Other Contact Name:

Other Phone:

Date of ITP:

Date of Discharge:

Date of Request:

MFP TRANSITION SERVICE	RATIONALE (provide justification for why this MFP service is needed to support successful living in the community)	MFP PARTICIPANT INITIAL

MFP Facilitator Name:

Region/Office:

Phone:

Email:

Notice: (Step 1) Send this completed *Request for Additional MFP Services* to the DCH/MFP Office via **File Transfer Protocol**. Contact the DCH/MFP Office regarding the dispensation of this request. (Step 2) If approved by DCH/MFP Office, submit completed reimbursement documentation (i.e. updated ITP, *Vendor Import File*, etc.) to Fiscal Intermediary via **File Transfer Protocol** and to DCH/MFP Office by **File Transfer Protocol**.

For DCH/MFP Office Use Only

Additional MFP Services Authorized: ☐ Yes ☐ No

Notes: